CUBA-RUSHFORD CENTRAL SCHOOL

Cuba-Rushford Middle/High School
5476 Route 305N, Cuba, NY 14727
585-968-2650 / Fax: 968-1091

Cuba-Rushford Elementary School
15 Elm Street, Cuba, NY 14727
585-968-1760 / Fax: 968-3181

NEW STUDENT REGISTRATION

Welcome to the Cuba-Rushford Central School District. We look forward to working with your child, and will do everything we can to make the transition a smooth one.

To begin the enrollment process, please review and complete the paperwork contained in the registration packet. We ask that you please PRINT clearly, except where a signature is required.

In addition to completing the registration packet, the information below must also be provided. Some of these items (i.e. birth certificate, immunizations) are often sent by the previous school along with the academic records. However, if they are not included it is your responsibility to submit any missing documentation.

Required Documentation:

- ✓ Child's birth certificate
- ✓ Child's immunization record
- ✓ Proof of residency (please refer to Residency Affidavit in packet for examples of acceptable documentation)
- ✓ Any relevant court papers (custody, order of protection, etc.)

Once we have received all the necessary paperwork, all academic records will be carefully reviewed so that your child can be scheduled appropriately. In the meantime, if you have any questions, please feel free to call the Guidance Office at 585-968-2650, extension 4416 at the MHS for grades 6-12 or call the Elementary office at 585-968-1760, extension 3109 for Pre-K – Grade 5.

CUBA-RUSHFORD CENTRAL SCHOOL **NEW STUDENT REGISTRATION** ***SCHOOL YEAR: 2025-2026***

FOR OFFICE USE ONLY

Enrollment Date_____ ☐ New Entry ☐ Re-Entry Student ID_____ Entry Date_____

Campus_____ Grade_____ CSE: ☐ Yes ☐ No RECEIVED: ☐ Records ☐ Birth Cert ☐ Immunizations ☐ POR

STUDENT_____ ☐ M ☐ F DOB _____/_____/_____
Last First Middle MM DD YYYY

Place of Birth_____ Home Phone ( )_____ Student's Cell ( )_____
City & State (or country if not USA)

Physical Address _____
Street (NO P.O.#) City State ZIP

Mailing Address _____
(IF DIFFERENT) Street or PO # City State ZIP

PARENT/GUARDIAN (Residing with Student) _____ Cell ( )_____
Last First

Relationship to Student _____ Email_____
(Mother, Father, Legal Guardian, etc.)

Employer _____ Work Phone ( )_____

PARENT/GUARDIAN (Residing with Student) _____ Cell ( )_____
Last First

Relationship to Student _____ Email_____
(Mother, Father, Legal Guardian, etc.)

Employer _____ Work Phone ( )_____

PARENT/GUARDIAN (*NOT* Residing with Student) _____Cell ( )_____
Last First

Relationship to Student _____ Email_____
(Mother, Father, Legal Guardian, etc.)

Address _____
Street City State ZIP

Employer _____ Work Phone ( )_____

☐ Check here if parent/guardian should receive grade reports. ☐ Check here if parent/guardian has joint custody.

PARENT/GUARDIAN (*NOT* Residing with Student) _____Cell ( )_____
Last First

Relationship to Student _____ Email_____
(Mother, Father, Legal Guardian, etc.)

Address _____
Street City State ZIP

Employer _____ Work Phone ( )_____

☐ Check here if parent/guardian should receive grade reports. ☐ Check here if parent/guardian has joint custody.

Is the student Hispanic, Latino, or of Spanish Origin? ☐ No, Not Hispanic ☐ Yes, Hispanic

Ethnic Group (please choose all that apply, but at least ONE):

☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

Previous School _____ Last Grade Completed _____
OR entering: PreK_____ K_____

City/State _____

School Phone _____School Fax _____

EMERGENCY CONTACTS: Please provide information for other adults who may be requested to act as a parent, either by you or the school, when necessary (please list in the order they should be called in the event a parent/guardian cannot be reached).

Name_____ Relationship to Student _____

Address _____Phone ( )_____ Phone ( )_____

Name_____ Relationship to Student _____

Address _____Phone ( )_____ Phone ( )_____

Name_____ Relationship to Student _____

Address _____Phone ( )_____ Phone ( )_____

CUSTODY INFORMATION: *PLEASE NOTE – If no legal documentation is provided stating otherwise, joint custody is assumed with both parents having equal rights and access to the student and all educational information.*

Parents are: ☐ Married ☐ Not married/reside together ☐ Divorced/Separated ☐ Not married/reside separately

Custody is: ☐ Joint ☐ Sole custody with _____ ***(we MUST have court documentation)***

Comments (please explain any special circumstance or situation not covered above):_____

_____

_____

HOUSHOLD INFORMATION: Please list all OTHER children in the home, including those not currently enrolled:

Name	M/F	Age	Date of Birth	Name	M/F	Age	Date of Birth

SPECIAL EDUCATION: Was your child receiving special education services? ☐ Yes ☐ No

If *Yes*, please check: ☐ IEP (please list classification) _____ ☐ 504 Plan

If your child is transferring to Cuba-Rushford with an IEP (Individual Education Plan), he/she will be temporarily placed in a CRCS program that most closely matches the program listed on the IEP until the CSE (Committee on Special Education) conducts it's review of the student's program and placement needs.

Permission for Temporary Placement: *I hereby agree to the temporary continuation of the classification and program in which my child was placed by the previous school.*

Parent/Guardian Signature _____ Date _____

NOTICE: Please be advised that any false information on this registration form could constitute a crime. In addition, the District reserves its right to recover from parents, legal guardians, or other responsible parties the entire actual cost of educating a student, plus related costs, for the entire period that any non-resident student is enrolled in a District school without authorization and/or under false pretenses.

CERTIFICATION: I hereby certify that the student listed on this registration form actually resides with me at the address specified. I further certify that all the information I provided on this registration form is true and correct. I understand that I must immediately notify the District if the residency of the student changes from the address listed on this registration form.

AUTHORIZATION: I authorize the request for student records from previous schools and give permission to the Cuba-Rushford Central School District to verify telephone numbers, addresses, and employment. I understand that if the District believes the information on this form is no longer correct or that the child being registered no longer lives at the address provided or with the parent(s) and/or guardian(s) listed, the Cuba-Rushford Central School District has the right under New York State law to investigate and to remove the child's enrollment from the Cuba-Rushford Central School District.

I have read and understand all of the information contained in this form.

Parent/Guardian (PLEASE PRINT) _____ **Relationship to Child** _____

Parent/Guardian Signature _____ **Date** _____

HOUSING QUESTIONNAIRE

Name of LEA: Cuba-Rushford Central School District

Name of School: _____
Elementary School (PK-5), Middle School (6-8), or High School (9-12)

Name of Student: _____
Last *First* *Middle*

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ Grade: _____ ID#: _____
Month Day Year *PK-12* *(optional)*

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (please describe):
- ☐ In a permanent residence (house or apartment) with parent/guardian

_____ _____

PRINT Name of Parent/Guardian, or Student (for unaccompanied homeless youth)

SIGNATURE of Parent/Guardian, or Student (for unaccompanied homeless youth)

_____

Date

CUBA-RUSHFORD CENTRAL SCHOOL

Residency Statement

I, _____, declare that I physically reside at:
(Parent/Guardian – PLEASE PRINT)

Street Address (NO P.O. #)_____

City, State, ZIP_____

Home phone # (_____)_____ Cell phone # (_____)_____

List Children: _____ _____

_____ _____

I also declare that I am in compliance with the State of New York laws requiring that students attend public school in the district in which they live with their parents or legal guardians, and that I have no other legal residence other than that listed on this affidavit. In order to verify my residence in the Cuba-Rushford Central School District, I have submitted ***(or will submit within 30 days)*** to the Guidance Office the following document(s) with my name and address:

- ☐ Current Utility Bill
- ☐ Cable/Phone Bill
- ☐ Lease/Rental Agreement
- ☐ Deed/Mortgage Documents
- ☐ Valid Driver's License
- ☐ Current Vehicle Registration
- ☐ Current Paystub
- ☐ Other_____

I declare that this information is true and accurate and, further, I am aware that the deliberate, intentional falsification of information for school attendance purposes is unlawful. I further understand that if statements made on this affidavit change, I must immediately notify the building principal of the Cuba-Rushford Central School District attended by my child(ren).

I am aware that if documentation is not provided within 30 days, OR if a student is found to have established residency in the Cuba-Rushford Central School District by providing false or inaccurate information, the student's enrollment will terminate immediately. Further, the parents/guardian may be held liable for all costs incurred while the student was enrolled in the Cuba-Rushford Central School District.

For secondary school students, I am aware that students are prohibited from participation in interscholastic competition for a school other than that which he/she legally attends. To falsify residency and to participate interscholastically would result in further penalties to the student, even if at some point following the violation he/she were to legally reside in the Cuba-Rushford Central School District.

Print Name: _____
(Parent/Guardian)

Signature: _____ Date Signed: _____
(Parent/Guardian)

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent of Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated.

Please write clearly when completing this section.

Student Name:

First | Middle | Last

Date of Birth: (Month / Day / Year)

Gender: ☐ Male ☐ Female

Parent/Person in Parental Relation Info:

Last Name | First Name | Relation to Student

HOME LANGUAGE CODE

LANGUAGE BACKGROUND
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other _____ Specify	
2. What was the first language your child learned?	☐ English	☐ Other _____ Specify	
3. What is the Home Language of each parent/guardian?	☐ Mother _____ Specify	☐ Father _____ Specify	☐ Guardian(s) _____ Specify
4. What language(s) does your child understand?	☐ English	☐ Other _____ Specify	
5. What language(s) does your child speak?	☐ English	☐ Other _____ Specify	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other _____ Specify	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other _____ Specify	☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

School District Information:	Student ID Number in NYS Student Information System
District Name (Number) & School / Address	

Home Language Questionnaire (HLQ) – Page Two

EDUCATIONAL HISTORY

8. Indicate the total number of years that your child has been enrolled in school. _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.
Yes* ☐ No ☐ Not sure ☐ *If yes, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?
☐ No ☐ Yes – Type of services received:_____
Age at which services received (Please check all that apply):
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g. special talents, health concerns, etc.)

_____

_____

12. In what language(s) would you like to receive information from the school? _____

_____ Month: _____ Day: _____ Year: _____

Signature of Parent or of Person in Parental Relation Date

Relationship to student: ☐ Mother ☐ Father ☐ Other:_____

Official Entry Only – Name/Position of Personnel Administering HLQ

Name:_____ Position:_____

If an interpreter is provided, list name, position, and credentials:

Name/Position of Qualified Personnel Reviewing HLQ and Conducting Individual Interview

Name:_____ Position:_____

Oral Interview Necessary: ☐ No ☐ Yes

**Date of Individual Interview _____ MO DAY YR	Outcome of Individual Interview ☐ Administer NYSITELL ☐ English Proficient ☐ Refer to Language Proficiency Team

Name/Position of Qualified Personnel Administering NYSITELL

Name:_____ Position:_____

Date of NYSITELL Administration: _____ MO DAY YR

Proficiency Level Achieved on NYSITELL: ☐ Entering ☐ Emerging ☐ Transitioning ☐ Expanding ☐ Commanding

For students with disabilities, list accommodations, if any, administered in accordance with IEP pursuant to CSE recommendation:

CUBA-RUSHFORD CENTRAL SCHOOL

New Student Questionnaire

STUDENT: _____ GR: _____

Date Enrolled: _____ Bus #: _____

Previous School: _____

Special Services/Needs (Please check any that your child received):

_____ IEP (Individualized Education Program)
_____ 504 Plan
_____ Title Program
_____ RtI (Response to Intervention)- Elementary
_____ Behavior Plan
_____ Counseling
_____ Homeless

Please list/describe any other academic services or extra help – formal or informal – your child received at his/her previous school:

_____
_____
_____
_____
_____

Other Special Needs/Requests/Information:

Please list anything you feel will help your child transition to his/her new school, including strengths/weaknesses, special requests, etc.:

_____
_____
_____
_____
_____

Cuba-Rushford Central School

MEDICAL HISTORY

Child's Name_____ ☐ Male ☐ Female Date of Birth_____

Address_____

Mother's Name _____ Phone_____

Father's Name _____ Phone_____

OR Guardian(s) _____ Phone_____

Child's Physician _____ Phone_____

GENERAL HEALTH

Has your child had a physical in the last year? ☐ Yes ☐ No

Do you consider your child's health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Can your child participate in all school activities, including sports? ☐ Yes ☐ No
If no, please explain_____

Please check any of the following that your child uses:

☐ Braces (arm/leg)
☐ Contact lenses
☐ Crutches
☐ Glasses
☐ Hearing aids
☐ Orthodontics
☐ Wheelchair
☐ Other_____

Check any below that your child has a history of or difficulties with:

☐ Anemia
☐ Bladder/kidney problems
☐ Chicken pox
☐ Chipped teeth
☐ Concussion/head injury
☐ Diabetes/sugar
☐ Epilepsy/seizures
☐ Falling/shaking
☐ Fractures/broken bones
☐ Frequent headaches
☐ Gastrointestinal problems
☐ Hearing loss
☐ Heart condition
☐ Heat exhaustion
☐ Hernia
☐ High blood pressure
☐ Measles
☐ Meningitis
☐ Mononucleosis
☐ Mumps
☐ Nose bleeds
☐ Staring/fainting spells
☐ Vision disorders/glasses
☐ Other_____

Please explain any of the above that you checked:_____

_____

_____

ALLERGIES

Does your child have any allergies? ☐ No ☐ Yes If yes, please check below and give details/reactions to:

☐ Bees/wasps/other insects_____

☐ Seasonal (i.e. Hay Fever)_____

☐ Food_____

☐ Medications_____

☐ Other_____

Does your child have an Epi Pen? ☐ No ☐ Yes Is your child receiving allergy shots? ☐ No ☐ Yes

Treatment recommended by child's physician in the event of a severe allergic reaction:_____

_____

Please be aware that we do not stock medications for severe allergic responses. Parents are responsible for providing these medications to the school nurse with the doctor's orders.

ASTHMA

Has your child been diagnosed with asthma by his/her physician? ☐ No ☐ Yes

If yes, what treatments/medications have been prescribed?_____

_____

Are there specific triggers that cause an asthma episode? ☐ No ☐ Yes

If yes, please describe these triggers:_____

_____

MEDICATIONS

Does your child take any medications, either on a part-time or regular basis? ☐ No ☐ Yes If yes, please explain:

Medications Given Daily	Medications Given Frequently

If your child needs to take medications in school, please contact the school nurse for the procedure to follow.

ILLNESS/INJURY/SURGERY

Has your child had any illness, injury, or surgery during the past 6 months? ☐ No ☐ Yes If yes, please explain:

_____

_____

_____

Please list previous injuries, illness, and/or surgeries, the year they occurred, and if hospitalization was required:

Injury/Illness/Surgery	Year	Hospitalized	Length of Hospital Stay
		No Yes	
		No Yes	
		No Yes	
		No Yes	

ADDITIONAL INFORMATION

Does your child have any disabilities or chronic illnesses? ☐ No ☐ Yes If yes, please explain:_____

_____

_____

_____

Are there any concerns that you would like to discuss with the school nurse? ☐ No ☐ Yes If yes, please explain:

_____

_____

_____

Please describe **ANY** condition or provide **ANY** other health information the school nurse, coaches, or athletic trainers should be aware of that has not already been covered on this form:_____

_____

_____

_____

Information given by (PLEASE PRINT)_____ Relation to child_____

Signature_____ Date_____

CUBA-RUSHFORD CENTRAL SCHOOL

Superintendent of Schools, 585-968-2650 x4425 / Fax: 968-2651
Transportation Supervisor, 585-968-2650 x4442

Middle/High School
5476 Route 305N, Cuba, NY 14727
585-968-2650 / Fax: 968-1091

Elementary School
15 Elm Street, Cuba, NY 14727
585-968-1760 / Fax: 968-3181

Health and Dental Examination Requirements

Dear Parents/Guardians:

New York State Law requires a health examination for all students entering the school district for the first time, and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grades. The examination must be completed by a New York State licensed physician, physician assistant, or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days, please notify the nurse's office and provide the date of the appointment.
- Communication between private and school health staff is important for the safe and effective care at school. Your healthcare provider may not share health information with the school health staff without your signed permission. Please talk with your provider about signing their consent form for the school at the time of your child's next health examination appointment.
- For your convenience, a physical exam form and a dental certificate for your health care providers are attached.

We suggest making copies of the completed forms for your own records before sending them to the school nurse's office.

2025-2026 REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

If your child has not had a physical in the past 12 months, he/she will need one to be eligible to play a sport at Cuba -Rushford. In that event, this form must be completed by the physician and returned to the school

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other: _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ NO ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Management Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI%>85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐<5th ☐5th-49th ☐50th-84th ☐85th-94th ☐95th-98th ☐99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥10 ug/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code

_____ _____
_____ _____
_____ _____
_____ _____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	**Notes**
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grade 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle		
Recommendations:				

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions, including Physical Education and Athletics.

☐ **Restrictions/Adaptations -** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** — **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** — **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

Dental Health Certificate – Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. Your child may have a dental checkup during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered hygienist for an assessment. If your child had a dental checkup before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1: To be completed by Parent or Guardian (Please Print)

Child's Name:
Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: (Name)

Grade:

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak, or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination, with x-rays if necessary, to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing, or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent/Guardian Signature: Date:

Section 2: To be completed by the Dentist/Dental Hygienist

I. The dental health condition of _____ on _____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, the student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, the student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists, including pain, swelling, or infection related to clinical evidence of open cavities, that interferes with a student's ability to chew, speak, or focus on school activities. The designation of *not in fit condition of dental health to permit attendance at the public school* does not preclude the student from attending school.

Dentist's/Dental Hygienist's name and address (please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections – If you agree to release this information to your child's school, please initial here: ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** - Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity.]

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.]

☐ Yes ☐ No **Dental Sealants Present**

Other problems (specify): _____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.